

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

92552

2526

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|---|---|---|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Worcester MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Worcester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City | | c. LENGTH OF STAY IN 1b minutes | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Market Street | | | | d. STREET ADDRESS 11 Front Street | | | |
| 3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;"> First CARL Middle MERRILL Last BRITTINGHAM </div> | | | | 4. DATE OF DEATH <div style="display: flex; justify-content: space-between;"> Month February Day 7 Year 1961 </div> | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Dec. 28, 1892 | | 9. AGE (In years last birthday) 68 yrs. <div style="display: flex; justify-content: space-between; font-size: small;"> Months Days Hours Min. </div> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant | | 10b. KIND OF BUSINESS OR INDUSTRY Service Station | | 11. BIRTHPLACE (State or foreign country) Virginia | | | |
| 13. FATHER'S NAME Lloyd Brittingham | | | | 14. MOTHER'S MAIDEN NAME Iva Merrill | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WW 1 | | 16. SOCIAL SECURITY NO. 227-24-0437 | | 17. INFORMANT John L. Brittingham, New Church, Va. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex;"> <div style="flex: 1;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 229X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Abdominal tumor (c) </div> <div style="flex: 1; font-size: small;"> INTERVAL BETWEEN ONSET AND DEATH four days OK </div> </div> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <div style="display: flex; justify-content: space-between;"> Hour a. m. 19 </div> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | | |
| 20f. (City or town) New Church | | (County) Stafford | | (State) Virginia | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE N. E. Sartorius, Sr. | | EXAMINER'S NAME (Type) N. E. SARTORIUS, SR. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Feb. 9, '61 | | 22c. NAME OF CEMETERY OR CREMATORY Brittingham Cemetery | | | |
| 22d. LOCATION (City, town, or county) Rural-New Church, Virginia | | (State) Virginia | | 24a. REC'D BY REGISTRAR FEB 14 '61 | | | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | | DATE FEB 14 '61 | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | |
|----------------------|--|----------------------------|--|
| Name of Deceased | | Date of Death | |
| Sex | | Age | |
| Race | | Place of Birth | |
| Usual Residence | | Place of Death | |
| Cause of Death | | Manner of Death | |
| Medical History | | History of Present Illness | |
| Physical Examination | | Laboratory Examinations | |
| Diagnosis | | Treatment | |
| Prognosis | | Remarks | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2527 CERTIFICATE OF DEATH 02503

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|--|---------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY | | c. LENGTH OF STAY IN 1b X OCEAN CITY | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS 1709 BALTO. AVE | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) DR. ROY First ALFRED Middle BUHRMAN Last | | 4. DATE OF DEATH Month FEB. Day 19 Year 1961 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 19, 1880 |
| 9. AGE (In years lost birthday) 80 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DENTIST | | 10b. KIND OF BUSINESS OR INDUSTRY RETIRED | |
| 11. BIRTHPLACE (State or foreign country) MYERSVILLE MD | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CHARLES A. BUHRMAN | | 14. MOTHER'S MAIDEN NAME COROLIA RAYMER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. NO | |
| 17. INFORMANT MRS. R. A. BUHRMAN | | Address OCEAN CITY MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 432 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Latent sclerotic cerebral vascular disease & old hemiplegia DUE TO (c) 6 years | | INTERVAL BETWEEN ONSET AND DEATH 1/2 hour | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1950 to 2/19 1961, that (I) (we) last saw the deceased alive on 2/19 1961, and that death occurred at 3:30 P. M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE N. F. Thomas | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) N. F. Thomas | | 22d. ADDRESS Ocean City, md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 2/21/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY PARSONS | | 23d. LOCATION (City, town, or county) (State) SAYERSBURY MD | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Anna R. Burbage Berlin Md. | | 25a. REC'D BY REGISTRAR DATE FEB 23 '61 | |
| 25b. REGISTRAR'S SIGNATURE C. F. Thomas | | | |

(1)

(2)



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, with the word "pending" in pencil in item 18, Give Pages 1, 2, 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2528

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12544

| | | | | | |
|--|--------------------|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Worcester MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Worcester | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Griddlestone (Rural) | | c. LENGTH OF STAY IN 1b years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Griddlestone (Rural) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | d. STREET ADDRESS R28 | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Peter First E. J. Conner Last | | | 4. DATE OF DEATH Month 2 Day 1 Year 1961 | | |
| 5. SEX M | 6. COLOR OR RACE C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct 1909 5-7 yrs. | | 9. AGE (In years last birthday) 51 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer in brick house | | 10b. KIND OF BUSINESS OR INDUSTRY Chicken raiser | | 11. BIRTHPLACE (State or foreign country) Va | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME Peter Conner | | |
| 14. MOTHER'S MAIDEN NAME Bessie Handy | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Not | | |
| 16. SOCIAL SECURITY NO. 212-14-7685 | | | 17. INFORMANT John Handy Griddlestone, Md | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 322.2 DUE TO (b) Head buried in pillow (face down) (c) Alcoholism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Heavy Cigarette Smoker - 3 packs or more a day. INTERVAL BETWEEN ONSET AND DEATH 10 Days | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE N. E. Sartorius Jr. | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) N. E. Sartorius Jr. M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF Feb 4/61 | | 22c. NAME OF CEMETERY OR CREMATORY Griddlestone | |
| 22d. LOCATION (City, town, or county) | | (State) | | 22e. REC'D BY REGISTRAR | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wayne D. Dumas | | ADDRESS Snow Hill, Md | | 24b. REGISTRAR'S SIGNATURE Arthur L. Brown | |

MEDICAL CERTIFICATION

THIS DEATH
CERTIFICATE

1. Name of Deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of Birth: *Jan 15, 1900*

5. Place of Birth: *Johns Hopkins, Md.*

6. Usual Residence: *123 Main St., Baltimore, Md.*

7. Date of Death: *Dec 10, 1945*

8. Time of Death: *10:30 AM*

9. Place of Death: *Home*

10. Cause of Death: *Myocardial Infarction*

11. Manner of Death: *Natural*

12. Signature of Medical Examiner: *[Signature]*

13. Signature of Coroner: *[Signature]*

14. Signature of Registrar: *[Signature]*

For use of the Medical Examiner only. This section contains fields for the medical examiner's findings, including a detailed description of the autopsy, the results of laboratory tests, and the final determination of the cause and manner of death. It also includes a section for the medical examiner's signature and the date of the report.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2529

Item 1 Film 6281 2-17-61 et

CERTIFICATE OF DEATH

02505

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|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN | | | | c. LENGTH OF STAY IN 1b X BERLIN | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home | | | | d. STREET ADDRESS 1 S. MAIN ST | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) MARY First H. Middle DAVIS Last | | 4. DATE OF DEATH FEB. Month 1 Day 1961 Year | | 5. SEX F | | 6. COLOR OR RACE W | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH MAY 2, 1879 | | 9. AGE (In years last birthday) 81 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) WHELEVILLE MD | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CHARLES W. COOPER | | | | 14. MOTHER'S MAIDEN NAME MARY DENNIS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT J. BAYARD DAVIS Address BERLIN MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 420.2 DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Asthma - Angina (c) Cardiac Asthma - Angina | | | | | | INTERVAL BETWEEN ONSET AND DEATH - ? - - ? - - ? - | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 8-1 1960 to 2-1 1961 , that (I) (we) last saw the deceased alive on 1-23 1961 , and that death occurred at 11:30 AM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Clifford E. Schott M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) CLIFFORD E. SCHOTT MD | | | | 22d. ADDRESS BERLIN, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 2/5/61 | | 23c. NAME OF CEMETERY OR CREMATORY EVERGREEN | | 23d. LOCATION (City, town, or county) (State) BERLIN MD | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage ADDRESS Berlin Md | | | | 25a. REC'D BY REGISTRAR FEB 15 '61 DATE | | 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |

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TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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2530

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02506

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|--|----------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> <u>Berlin Nursing Home</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKE CITY</u> 43 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BERLIN NURSING HOME</u> | | | | d. STREET ADDRESS <u>WINTER QUARTER'S DRIVE 1</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>J.</u> Last <u>East</u> | | | | 4. DATE OF DEATH Month <u>Feb</u> Day <u>9</u> Year <u>1961</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>OCT. 31, 1881</u> | | 9. AGE (In years last birthday) <u>79</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>SAMUEL WESSELLS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>GEORGIE ANNA YOUNG</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | | |
| 17. INFORMANT <u>MRS. OADEN W. HURLEY</u> | | | | Address <u>POCOMOKE CITY, MD.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chr Myocarditis + acute attack</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chr. Bronchitis</u> DUE TO (c) <u>Coronary atherosclerosis</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 22 - 1961</u> to <u>Feb 8 - 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 8 - 1961</u> , and that death occurred at <u>7:45 AM</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Chas R. Law</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>Feb 9 - 1961</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>CHAS. R. LAW</u> | | | | 22d. ADDRESS <u>BERLIN, MARYLAND</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>2-12-61</u> | | 23c. NAME OF CEMETERY <u>DOWNING METHODIST</u> | | 23d. LOCATION (City, town, or county) (State) <u>OAK HALL, VIRGINIA</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u> | | | | ADDRESS <u>POCOMOKE CITY, MD.</u> | | 25a. REC'D BY REGISTRAR DATE <u>FEB 14 '61</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u> | | | |

MEDICAL CERTIFICATION

2531

CERTIFICATE OF DEATH

Reg. Dist. No.

02517

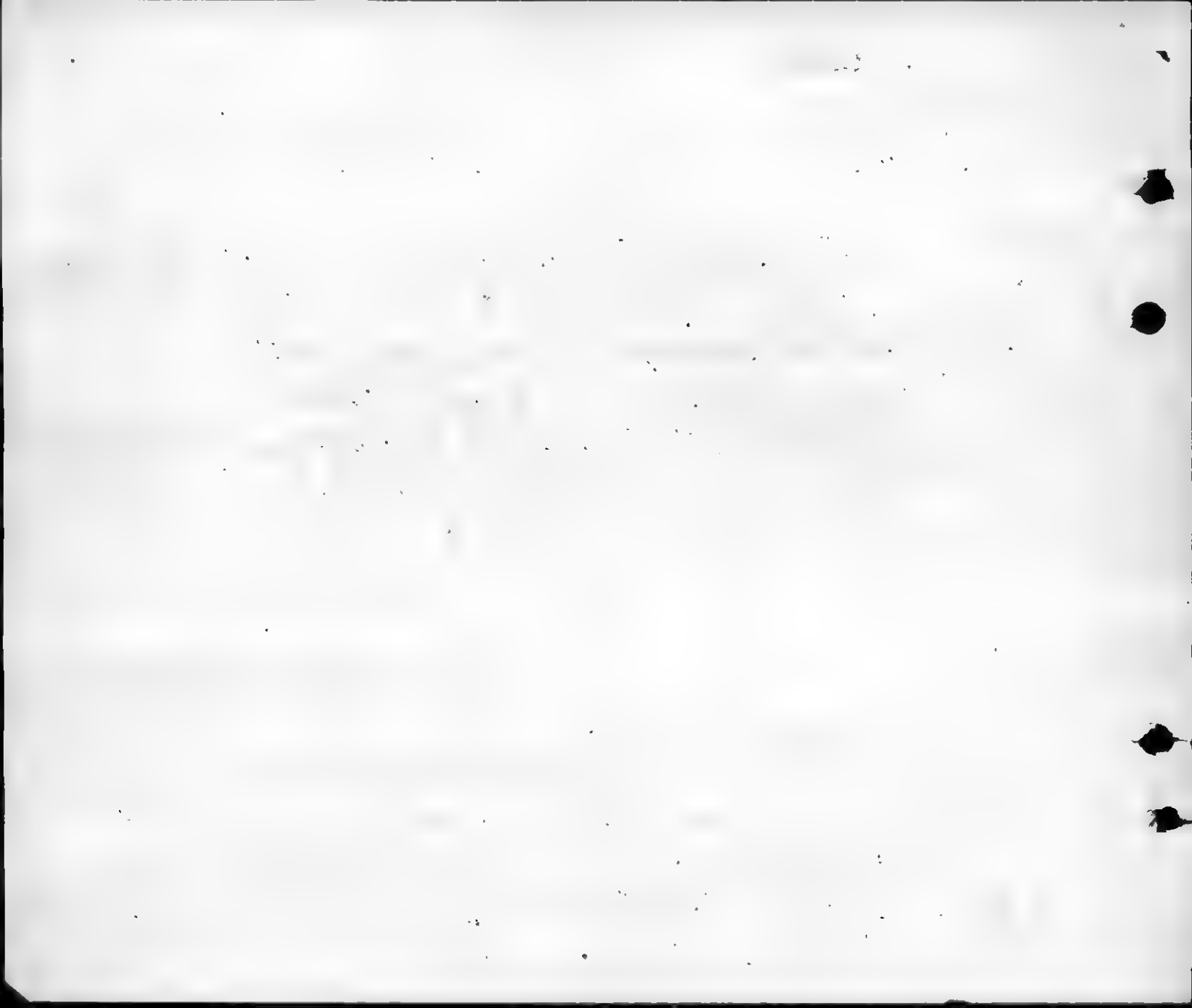
| | | | |
|--|---|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> | | c. LENGTH OF STAY IN lb <u>69 yrs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>J.</u> Last <u>Godfrey</u> | | 4. DATE OF DEATH Month <u>Feb</u> Day <u>7</u> Year <u>1961</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 25 - 1891</u> |
| 9. AGE (In years last birthday) <u>69 7/12</u> | | 10. IF UNDER 1 YEAR Months <u>7</u> Days <u>12</u> Hours <u>12</u> Min. <u>12</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refrigerator Mechanic Garage</u> | | 11. BIRTHPLACE (State or foreign country) <u>Snow Hill, md</u> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <u>Frank Godfrey</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Rebecca Marvel</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | |
| 16. SOCIAL SECURITY NO. <u>215-10-7632</u> | | 17. INFORMANT <u>Mrs. Ida C. Godfrey, Snow Hill, md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420-0</u> DUE TO <u>Acute myocardial infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AS H D.</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Prostate</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>61</u> , to <u>Feb</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2/7</u> , 19 <u>61</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>David Rafat</u> M.D. | | ADDRESS (Street, city or town, state) <u>104 Bay Street</u> DATE SIGNED <u>2-7-61</u> | |
| PHYSICIAN'S NAME (Type) <u>David Rafat, M. D.</u> | | Snow Hill, Maryland | |
| 22. BURIAL, CREMATION, or REMOVAL (Specify) <u>Buried Feb 9/61</u> | | 22b. DATE THEREOF | |
| 23. NAME OF CEMETERY OR CREMATORY <u>Whatcoat Cemetery</u> | | 22d. LOCATION (City or town, county) (State) <u>Snow Hill, md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Dennis</u> ADDRESS <u>Snow Hill, md</u> | | 24. REC'D BY REGISTRAR <u>Feb 9 '61</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u> | | | |

Page 4 within 24 hours of death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

VS A15 (4)
15M 9/58

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 2532

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> | |
| c. LENGTH OF STAY IN 1b <u>5 yrs.</u> | | d. STREET ADDRESS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Helen</u> First <u>Johnson</u> Middle <u>Johnson</u> Last | | 4. DATE OF DEATH <u>Feb.</u> Month <u>3</u> Day <u>1961</u> Year | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Mar. 13, 1912</u> 48 yrs. |
| 9. AGE (In years, last birthday) <u>48</u> | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William Waters</u> | | 14. MOTHER'S MAIDEN NAME <u>Susie Brittingham</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT <u>Corbinell Johnson Pittet St. Snow Hill, Md.</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332-2</u> DUE TO <u>Heart Attack</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>For much smoking, 5 years ago</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Exhaustion, cold, wet and cold</u> | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>2-9-61</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u> | | 24a. REC'D BY REGISTRAR DATE <u>Feb 14 '61</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | | DATE SIGNED <u>2/4/61</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. To execute the certificate, write the word "pending" in pencil in item 18. Give Pages 1, 2, 3, and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

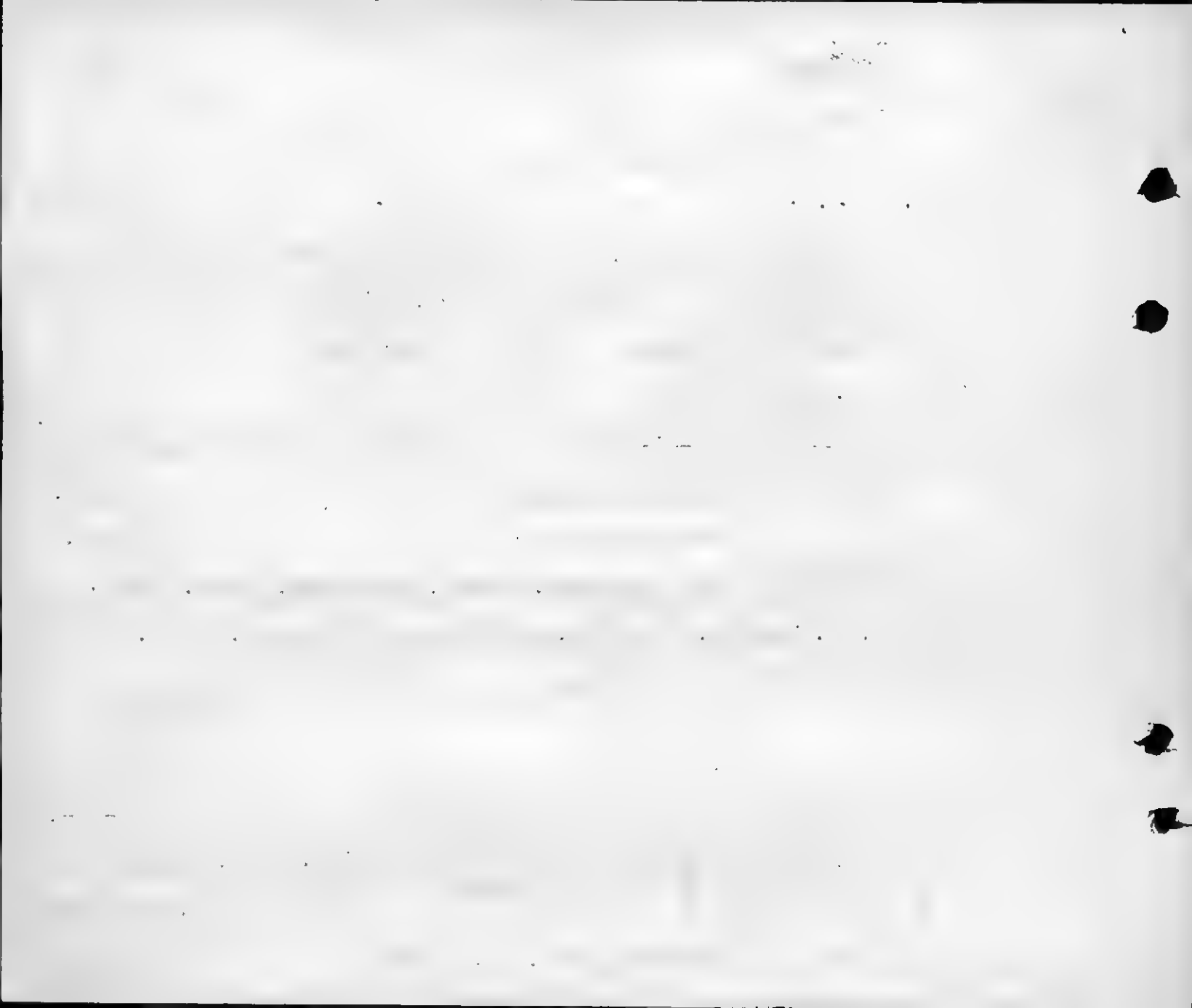
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2533

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

025-1

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Worcester MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Worcester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) 414 Cedar Street | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City | |
| f. STREET ADDRESS 414 Cedar Street | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JOSHUA Middle T. Last MASON | | 4. DATE OF DEATH Month February Day 18 Year 1961 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 26, 1874 |
| 9. AGE (In years last birthday) 86 yrs | | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman & Sawyer | | 10b. KIND OF BUSINESS OR INDUSTRY Lumber | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Stephen T. Mason | | 14. MOTHER'S MAIDEN NAME Ellen Hudson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -- | | 16. SOCIAL SECURITY NO. 213-05-2120A | |
| 17. INFORMANT Mrs Elizabeth Mason, Pocomoke City, Md. | | Address 414 Cedar St. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO 422-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO 13 mos. (c) Arteriosclerosis, chronic, generalized, severe. 13 mos. | | INTERVAL BETWEEN ONSET AND DEATH 14 hrs. 13 mos. 13 mos. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (1) Hernia, rt. inguinal, to scrotum, severe (2) Chronic Bronchitis, severe. | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 22 Jun 1960 to 18 Feb 1961 that (I) (we) lost saw the deceased alive on 18 Feb 1961 , and that death occurred at 2:30 P M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE N. E. Sartorius, Jr. | | 22b. DATE SIGNED 2-19-61 | |
| 22c. PHYSICIAN'S NAME (Type) N. E. SARTORIUS, JR. | | 22d. ADDRESS Pocomoke City, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Feb. 21, 1961 | |
| 23c. NAME OF CEMETERY First Baptist | | 23d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson | | 25a. REC'D BY REGISTRAR FEB 23 '61 | |
| ADDRESS Pocomoke City, Md. | | 25b. REGISTRAR'S SIGNATURE Calvin E. Kneass | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2534

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

112510

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY WORCESTER | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN | | c. LENGTH OF STAY IN 1b 12 | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LIBERTY TOWN R.F.D. | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ALEX NYAKAS | | 4. DATE OF DEATH Month Day Year FEB 25 1961 | | 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 1870 | | 9. AGE (In years lost birthday) yrs 91 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 11. BIRTHPLACE (State or foreign country) HUNGARY | | 12. CITIZEN OF WHAT COUNTRY? HUNGARY | |
| 13. FATHER'S NAME ALEX NYAKAS | | 14. MOTHER'S MAIDEN NAME unknown | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO NO | | 17. INFORMANT Address Mrs. JOSEPH KNAPP, BERLIN MD, RFD | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) DUE TO Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Hypertension (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 | | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Berlin | | 20g. (County) MD | | 20h. (State) MD | | 21. I certify that (I) (this hospital) attended the deceased from Jan 1 1961 to Feb 25 1961 that (I) (we) last saw the deceased alive on 2-25-61 19 and that death occurred on Feb 25 1961 from the causes and on the date stated above | | | |
| 22a. SIGNATURE Clifford E. Schott | | 22b. DATE SIGNED Feb 25 1961 | | 22c. PHYSICIAN'S NAME (Type) CLIFFORD E. SCHOTT MD | | 22d. ADDRESS BERLIN, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 2/28/61 | | 23c. NAME OF CEMETERY OR CREMATORY RIVERSIDE | | 23d. LOCATION (City, town, or county) BERLIN | | (State) MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Anne A. Burbage | | 24b. ADDRESS Berlin MD | | 25a. REC'D BY REGISTRAR DATE MAR 1 '61 | | 25b. REGISTRAR'S SIGNATURE William E. House | | | |



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2535
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

112511

| | | | | | | | |
|--|---|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> c. LENGTH OF STAY IN 1b <u>60 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>B.</u> Last <u>Payne</u> | | | | 4. DATE OF DEATH Month <u>Oct.</u> Day <u>25</u> Year <u>1961</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 1 - 1882</u> | 9. AGE (In years last birthday) <u>78 4/24</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | IF UNDER 24 HRS Hours <u> </u> Min <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Airldrie, md</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Elijah Barnes</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mary G. Hudson</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Mrs. J. Edward Primer, Snow Hill, md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>AS H D.</u> DUE TO <u>Diabetes</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u> <u>years</u> <u>5 years.</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1960</u> to <u>Feb 25 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 25 1961</u> , and that death occurred at <u>6AM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>David Rafat-md</u> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED <u>2-25-61</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>DAVID RAFAT</u> | | 22d. ADDRESS <u>Snow Hill Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Feb 27/61</u> | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY <u>Whalecat Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Snow Hill, md</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Gimmis</u> | | ADDRESS <u>Snow Hill, md</u> | | 25a. REC'D BY REGISTRAR <u>FEB 28 '61</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2536 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 FilmG281 2-27-61 et

Reg. Dist. No. 02513

| | | | |
|--|---------------------------|--|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill, Worcester Co.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill, Md.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First <u>Jane</u> Middle <u>Smith</u> Last <u>Smith</u> | | 4. DATE OF DEATH Month <u>Feb</u> Day <u>17</u> Year <u>1961</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/11/35</u> |
| 9. AGE (in years) <u>38</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labrer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>House wife</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Georgia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Joseph Thomas</u> | | 14. MOTHER'S MAIDEN NAME <u>Ellen Lacy Jones</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>1-11-11-11-11</u> | |
| 17. DEPENDENT <u>Ray E. Dennis</u> | | Address <u>Snow Hill Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Homicide by firearm (Gun)</u> DUE TO <u>981X</u> Conditions, if any, which gave rise to immediate cause (b) <u>None</u> DUE TO <u>None</u> cause last. (c) <u>None</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>The accused had been drinking</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>5-27-61</u> a.m. <u>5</u> p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. CITY or town (County) (State) <u>Snow Hill Worcester Md</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>N. E. Sartorius</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>N. E. Sartorius</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Feb 29 1961</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>County Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Snow Hill Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray E. Dennis</u> | | ADDRESS <u>Snow Hill, Md</u> | |
| 24a. REC'D BY REGISTRAR FEB 23 '61 | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u> | |

VS. A15ME
SM 2/57

5288 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH

[Faint, mostly illegible handwritten text and markings on a medical certificate form. The form includes sections for patient information, medical history, and cause of death.]

MASSACHUSETTS DEPARTMENT OF HEALTH
BOSTON
RECEIVED
JAN 10 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2537
CERTIFICATE OF DEATH
02514

| | | | | | | | |
|--|--|--|--|--|--|--------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Worcester MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Stockton | | | | c. LENGTH OF STAY IN 1b 3 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION Box 46 | | | | d. STREET ADDRESS Box 46 | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last JAMES STOCKLEY WILSON | | | | 4. DATE OF DEATH February 15 1961 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Dec. 27, 1886 | |
| 9. AGE (In years last birthday) 74 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | | | 10b. KIND OF BUSINESS OR INDUSTRY General Painting | | | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME William James Wilson | | | | 14. MOTHER'S MAIDEN NAME Florence Churn | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No -- | | | | 16. SOCIAL SECURITY NO. 212-14-3824 | | | |
| 17. INFORMANT Mrs Marie C. Wilson, Stockton, Maryland | | | | Address Box 46 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-20-0 DUE TO Cardiac Rhythmia Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO Cor Pulmonale (c) (A.S.H.D.) — | | | | INTERVAL BETWEEN ONSET AND DEATH. 72 min. Years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept. 1960 to Feb. 1961, that (I) (we) last saw the deceased alive on Feb. 14, 1961, and that death occurred at 8 AM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE David Rafat | | | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type) David Rafat, M.D. | | | | 22d. ADDRESS 104 Bay St., Snow Hill, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 2-18-61 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Saint Paul's Cemetery | | | | 23d. LOCATION (City, town, or county) (State) Druid Hill Park Balto. Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John C. Miller Inc. - 2431-35 E. Oliver St. | | | | 25a. REC'D BY REGISTRAR DATE FEB 17 '61 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

2023

UNITED STATES OF AMERICA

IN SENATE

January 10, 1907

REPORT

OF THE

COMMISSIONERS

OF THE

LAND OFFICE

ALBANY, N. Y.:
J. B. LIPPINCOTT & CO.,
PRINTERS.
1907.